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medical data logistics

UNDERPAYMENT RECOVERY

CASE STUDIES IN EFFICACY

# TRANSFER DRG

## A Secondary, Retrospective Underpayment Review

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# TRANSFER DRG

## A Second Retrospective Underpayment Review

## OVERVIEW

Medicare underpayments occur when a patient is discharged as a “transfer,” but there is no post-acute care (PAC) billing. This often happens when a patient decides to forego the recommended PAC after discharge. Accurate transfer coding at the time of discharge is difficult, if not impossible, as it requires that the discharge staff know what the patient will do in the future--not merely what the patient is advised- or intends to do.

Unless a specific underpayment audit is conducted for these cases, the revenue loss will persist and continue to grow.

**In this case study, we will look at one facility’s decision to perform a “second look” four-year retrospective review and ROI delivered.**

## THE CLIENT

The client is a standalone, 217-bed facility in the San Francisco Bay area, averaging 2600 annual Medicare Discharges between 2009 and 2013. Like most facilities, the hospital does not possess dedicated IT and data mining analyst resources in-house to conduct thorough and ongoing underpayment audits. Instead, the client decided to utilize third-party services to manage the process on their behalf.

## SITUATIONAL ANALYSIS

The hospital sought to perform a secondary, four-year retrospective review of Medicare underpayment claims that had previously been examined by another vendor specializing in Transfer DRGs.

The client, having used a well-regarded Transfer DRG service previously, additionally understood that the technology used by the chosen vendor could directly impact the number of eligible claims discovered & paid. It was this insight that led to their decision to engage a new vendor to recuperate claims missed during the first review.

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## SOLUTION

For the secondary retrospective review, the facility selected Medidal Corporation, a healthcare technology services company that both specializes in the "intelligent" claims automation and met all vendor requirements. The four key selection criteria were:

1. **A thorough understanding of Transfer DRG rules, security & compliance standards.** Strict HIPAA adherence is, of course, absolutely required. The Centers for Medicare and Medicaid Services (CMS) is responsible for creating and enforcing, through revoked access or the Department of Justice, Transfer DRG rules and regulations. Failure to monitor this landscape and implement changes as needed not only minimizes successful underpayment adjustments, but can also put the company at risk.

2. **A track record of success.** Transfer DRG success is easily defined: your facility is looking for the service that will provide the most claims and dollars—and quickly. As noted previously, the vendor's technology will largely determine the number of eligible claims discovered & paid. Not all solutions are created equal.

3. **Speed and accuracy.** Automated solutions reduce human error and can conduct full, comprehensive reviews of 100% of the claims much more quickly; services that rely largely on manual processes typically "cherry pick" rather than perform full review. For a four-year retrospective underpayment audit, each day that passes can mean more untimely claims and lost revenue.

4. **End-to-end process management.** Perceived reduced up-front fees can shift costs back to the client; cost benefits gained through outsourcing may be reduced due to the use of in-house resources & training. Services that rely too heavily on RAC audits need to be carefully vetted as well: many services will also look only at a sampling of claims, usually those with the highest potential dollar value, often resulting in substantial missed volume revenue opportunities.

## RESULTS

Medidal conducted a comprehensive review of 100% of Medicare claims between September 2009 and May 2013.

In addition to those eligible claims Medidal found adjusted during the previous company's review, Medidal further discovered more underpayments claims—137% more—for which the facility was subsequently reimbursed. Medidal's findings represented a 3.5% total underpayment discovery rate across all Medicare claims, which resulted in over $385,000 in additional DRG revenue for the hospital.

Medidal operates on a contingency-based fee schedule, and the return for the facility was significant, an ROI yield of 80%.

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## ABOUT MEDIDAL

Medidal Corporation is a healthcare technology services company that offers revenue cycle solutions existing healthcare systems were not designed to accommodate. Over the past 10 years, their “intelligent” software algorithms and compliance & insurance expertise have resulted in an innovative suite of product offerings that are best in class.

Medidal has electronic transaction capabilities for Medicare and Medicaid in all 50 states and the District of Columbia. The engineering team practices agile development methodologies, which coupled with rigorous industry & standards monitoring, ensures their Transfer Recovery and Eligibility products remain on the cutting edge of technological innovation and automated revenue cycle solutions.

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